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IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF MARICOPA

In the Matter of the Rehabilitation of:	)	NO. CV 99-20461
	)	PETITION NO. 25
PREMIER HEALTHCARE, INC. d.b.a. PREMIER HEALTHCARE OF ARIZONA,	)	PETITION FOR ORDER FOR APPROVAL OF FIRST INTERIM REPORT OF RECEIVER
an Arizona corporation.	)	
	)	(Assigned to Honorable J. Kenneth Mangum)

Charles R. Cohen, Receiver (hereinafter "Receiver") of Premier Healthcare, Inc., d.b.a. Premier Healthcare of Arizona ("Premier") respectfully submits this Petition which presents the Receiver's First Interim Report to the Court and requests that the Court enter an Order approving the Report.

A. General Background of Premier

1. Premier is an Arizona domiciled health care services corporation ("HCSO"), which arranged for health care services through health care plans as set forth in A.R.S. §20-1051 et seq. Premier was licensed and operated only in Arizona. Premier is a wholly-owned subsidiary of

MatureWell, Inc. ("MatureWell"), a Delaware corporation.[1] On November 16, 1999, Premier became subject to the "Order for Appointment of Receiver and Issuance of Permanent Injunction" ("Order") issued by this Court. The Order includes a finding that Premier is insolvent.

2. Premier was originally licensed by the Arizona Department of Insurance ("ADOI") in 1995. It was owned by nine regional physician/hospital organizations ("PHOs"). These PHOs also contracted with Premier to provide health care to its enrollees. Premier did business with the U.S. Health Care Financing Administration ("HCFA"), providing an HMO product, known as a "Medicare+Choice" plan, to persons entitled to Medicare benefits. HCFA is a federal agency that administers the Medicare program, and oversees the contract performance of Medicare+Choice HMOs. Premier also engaged in "commercial", or non-Medicare, business issuing health plans to various groups in the private market.

3. Premier operated throughout Arizona and on November 16, 1999, the date that this Court entered its Order, Premier had approximately 75,000 enrollees. Of this number, approximately 20,000 were Medicare enrollees and the remaining were commercial enrollees of Premier. The commercial enrollees were for the most part members of employer groups with contracts with Premier.

4. Premier arranged for health care services primarily through the use of contract health care providers, both on a reduced fee for service basis and a capitation basis. The Premier enrollee contracts also provide for out-of-service care by non-contract providers under certain circumstances.

5. Arizona law does not provide guaranty fund coverage of obligations of an HCSO. Instead, Arizona law requires that each HCSO licensed in Arizona have a plan for risk of insolvency which provides for (i) continuation of benefits for the duration of the enrollee or group contract period or for sixty days from the date insolvency is declared, which ever is *longer*, and, (ii) continuation of benefits to members who are confined on the date of insolvency

[1] On February 24, 2000, three MatureWell creditors filed an involuntary Chapter 7 petition against MatureWell in the U.S. Bankruptcy Court for the District of Arizona, Phoenix Division, thereby commencing Case No. 00-1781-GBN. MatureWell defaulted and counsel for the petitioning creditors asked for the entry of the Order for Relief. On March 29, 2000, Chief Bankruptcy Judge George B. Nielsen, Jr. entered an Order for Relief under Chapter 7 of U.S.C. Title 11. Dale Ulrich was appointed Chapter 7 Trustee of MatureWell.

in an inpatient facility until their discharge. Premier had such a plan in place and, pursuant to Arizona law and the finding of insolvency contained in the Order, the Receiver has implemented the provisions of the plan.

B. Receivership Activity and Status of Receivership

I. Implementation of Plan for Risk of Insolvency

6. As required by state law and the Order, the Receiver has implemented Premier's Plan for Risk of Insolvency. The primary feature of Premier's Plan for Risk of Insolvency is a reinsurance agreement whereby the reinsurer, General Reinsurance Corporation ("Gen Re"), is, in the event of the insolvency of Premier, responsible for payments in connection with Premier's obligation to continue to provide benefits as set forth in paragraph 5, above. A.R.S. §20-1069(C) requires, and Premier had obtained prior to receivership, an actuarial memorandum describing the basis on which an actuary had concluded that Premier's Plan for Risk of Insolvency met the statutory requirements to continue benefits. As set forth in A.R.S. § 20-1069(B), an enrollee's entitlement to continuation of benefits is contingent on timely payment of the premium by the enrollee or by the enrollee's representative to the Receiver. Premium payments attributable to the post-receivership time period (November 16, 1999 and after) and the reinsurance funds are the pool of funds from which the Receiver will pay post-receivership claims pursuant to the requirements of A.R.S. § 20-1069.[2] Gen Re is entitled to all premiums collected by the Receiver beginning on November 16, 1999, less administrative expenses of the Receiver relative to the Plan for Risk of Insolvency, and the Receiver is responsible for premiums due but uncollected.[3] Based upon present projections, including preliminary work

[2] Post-receivership obligations of the Receiver are administrative level claims, the highest priority in the statutory scheme for distribution of receivership assets. Therefore, the Receiver's obligation to continue benefits is a post-receivership obligation which is a class one claim pursuant to ARS § 20-629 (A).

[3] Significant uncollected premium arose due to former Management's practice of affording coverage to employer groups who failed to remit premium. Considering that such premiums had been deducted from employees' checks by employers, but then not remitted to Premier by such employers, the Receiver first had to update eligibility roles and, second, pursue premiums from employers. The Receiver continues to pursue employers for post receivership uncollected premiums which as of May 1, 2000 total $3.0 million (as compared with $2.6 million due from Gen Re as set forth above).

performed by actuaries engaged by the Receiver,[4] the Receiver believes Premier will have sufficient funds from premium payments attributable to the post-receivership time period and Gen Re reinsurance funds to pay all valid post-receivership claims in full.

7. An accounting of premiums and claims during the Plan for Risk of Insolvency period (November 16, 1999 through June 1, 2000) under the Reinsurance Agreement is as follows:

Premium Collected	$ 9.7	million
Less: Claims Paid [5]	< 12.8>	million
Due Premier by Gen Re:	<$ 2.6>	million

8. Attached hereto as **Exhibit 1** is a schedule which sets forth the premium attributable to the post-receivership time period and general categories of post-receivership claims paid. The Receiver has attempted, within the circumstances of the Receivership, to process post-receivership claims in the same fashion that claims would have been processed by Premier in the absence of a Receivership. That is, each claim or capitation payment was and continues to be determined or adjudicated as soon as the circumstances permit, which was made complicated because of the eligibility issues discussed more fully below, and then paid with the payment being accounted for by the Receiver as a post-receivership continuation of benefits claim. However, certain providers, like Premier's prescription service provider, at the inception of the receivership, demanded daily payment of claims in order for this vital service to continue. While out of the ordinary and putting great strain on the Premier's limited administrative and financial resources, the Receiver was faced with the Hobson's Choice of paying the prescription provider daily as demanded or paying in the ordinary course of the Plan for Risk of Insolvency and risking interruption of the provision of prescriptions to thousands of Premier's enrollees, expensive and time consuming litigation between the Receiver and the provider and the more important potential life threatening result of enrollees forgoing prescriptions. The Receiver

[4] See Ex Parte Petition 11, Ex Parte Petition for Approval of Amendment to Engagement Agreement with Managed Care Consulting Firm of Schaller Anderson, approved by the Court on February 7, 2000.

[5] Not inclusive of administrative expenses of the Receiver related to implementation of the Plan for Risk of Insolvency.

exercised his judgment to pay these claims to continue the relatively uninterrupted provision of prescription services to its enrollees. These post-receivership prescription claims have been paid in full because of the transition of all remaining Premier enrollees effective no later than May 1, 2000.

9. Claims from hospitals and physicians are processed with other claims on a first in first out basis but because hospital claims are in reality made up of dozens if not hundreds of lesser individual claims, hospital claims take much longer to process. This has resulted in the later payment of the hospital claims but those claims are continuously being processed as are others.

10. As of June 1, 2000, the Receiver has processed 53,599 basic contract and non-contract post-receivership claims totaling $8,081,770. Of this total, $4,922,670 has been paid to physicians and $3,159,100 to hospitals. Valid post-receivership claims are currently being processed and paid within one week of receipt. Post-receivership prescription claims paid total $2,888,901. Post-receivership capitation payments to providers total $1,333,479. Therefore, in summary, the Receiver has paid $12,304,150 of post-receivership claims, compared with premiums collected of $9,668,755, and premiums uncollected of $3,010,950, for a total post-receivership premium amount of $12,679,705.

II. Notices Issued

11. Throughout the course of this receivership, it has been a priority to communicate pertinent information to enrollees, providers and other interested persons. Since the commencement of the receivership, the Receiver has issued numerous informational notices in connection with the receivership. Approximately 129,000 notices have been sent by the Receiver to enrollees, employer groups, brokers, providers, collection agencies and others related to the receivership of Premier. These notices include the following:

a. On November 17, 1999, a notice was mailed to all of the Premier's employer groups and enrollees. This notice, a copy of which is attached here to as **Exhibit 2**, was pursuant to Premier's obligation under A.R.S. § 20-1069.01. That statute provides that with respect to enrollees who are members of a group with more than one insurance carrier, upon the insolvency of the HCSO, all other such carriers must offer such group members who are enrollees of the

insolvent HCSO a thirty day open enrollment period beginning on the date the insolvency is declared. The statute requires the insolvent HCSO, in this case Premier, to notify each group contract holder of the insolvency and each group contract holder to notify its remaining carriers of the insolvency and its members of their right to open enrollment. Premier satisfied this requirement by the immediate provision of the notice set forth in **Exhibit 2**.

b. On November 18, 1999, the Receiver mailed a notice to Premier's contract and non-contract providers. A copy of this notice is attached hereto as **Exhibit 3**. This provider notice, among other things, informed the providers of the receivership and insolvency of Premier and reminded the providers that Arizona law, the Order and the Premier Provider Service Agreements prohibit any effort by contract providers to bill or take any action to collect amounts owed to the providers on behalf of Premier enrollees by Premier.

c. On November 26, 1999, the Receiver, in conjunction with and on behalf of HCFA, mailed notices to the approximately 20,778 Premier Medicare enrollees. This notice is attached hereto as **Exhibit 4** and informed the Medicare beneficiaries that HCFA terminated its contract with Premier effective December 1, 1999. The Receiver's notice advised that if other Medicare+Choice plans were available in their counties, Medicare beneficiaries could elect to enroll with an alternative Medicare+Choice plan effective December 1, 1999. If not, the beneficiaries automatically returned to "traditional" fee-for-service Medicare.

d. Since the Plan for Risk of Insolvency provides for the continuation of coverage until the end of the Group Service Agreement Contract period or sixty (60) days, whichever is *longer*, the Receiver has in advance on a monthly basis, beginning on or about January 1, 2000, advised employers and enrollees of the specific upcoming termination dates of their contracts, for groups (i) affected by the sixty-day period (January 15, 2000) and (ii) whose effective date for the Group Service Agreement falls in months beginning with February 2000. A sample of this communication to employer groups is attached hereto as **Exhibit 5**. From the outset of the receivership, the Receiver sought to minimize the number of groups which terminated automatically, by transitioning the remaining membership with other carriers, as discussed in more detail below. The Receiver provided each of the employer groups with

information regarding their right to contact and secure alternative coverage from in excess of eighty insurers on the "Arizona Accountable Health Plan" listing (see **Exhibit 5**).

e. The Receiver has had continuous contacts, both written and telephonic, with providers subsequent to the initial notice on November 18, 1999, advising them of the Receivership. On November 19, 1999, Director of the Arizona Department of Insurance, in his capacity as Insurance Director and not as the Receiver, appealed to providers directly to continue to provide services during the transition (see **Exhibit 6**), and again on December 14, 1999 (see **Exhibit 7**). The letter set forth in **Exhibit 7** specifically requested providers to continue to honor the terms of their Provider Service Agreements by **not** (i) pursuing enrollees for balances due; (ii) refusing to see enrollees; (iii) requiring payment in advance as a condition to seeing enrollees; (iv) limiting services to "emergency services"; and (v) terminating their Provider Service Agreements. Although the Provider Service Agreements prohibit physicians and hospitals from each of the above actions (as does this Court's Order), many providers attempted to ignore the terms and conditions of their Provider Service Agreements.

f. On February 24, 2000, the Receiver mailed 44,000 notices directly to current and former enrollees advising them of the law in this regard and to therefore resist these attempted violations by physicians and hospitals under their Provider Service Agreements (see **Exhibit 8**).

g. Throughout the course of the Receivership, as the Receiver has been apprised of attempts by providers to violate the terms and conditions of their Provider Service Agreements, personalized letters have been mailed to such providers, as follows:

	Violation	NumberSent
Exhibit 9	Billing enrollees	919
Exhibit 10	Refusing service	75
Exhibit 11	Termination	31

As a result of these communications, contract providers have continued to provide care to enrollees and ceased any collection efforts against enrollees.

h. Further, the Director of the Arizona Department of Insurance (“ADOI”), has issued numerous press releases and bulletins (some of which are enclosed as **Exhibit 12**) relating

to the status of Premier, the unlawfulness of efforts by providers to attempt to collect from Premier enrollees and the need for providers to continue to provide services to Premier enrollees including the ability of the Receivership to pay for such services. The ADOI has also created on its website a section which provides current information about the Premier receivership (www.state.az.us/id/premier/premier.htm).

III. Enrollee Transition.

12. Premier is insolvent and other than through the provisions of the Plan for Risk of Insolvency which only provide for the continuation of benefits for the statutorily mandated periods, Premier cannot pay benefits on an ongoing basis. Coverage by Premier is limited to the longer of sixty (60) days from the date of insolvency or the duration of the contract period. Accordingly, Premier's enrollees have moved to other carriers.

13. From the outset of the Receivership, the Receiver has sought to market the business of Premier to other viable carriers.

14. The day following the Order, on November 17, 1999, the Receiver's representatives met with the Arizona Association of Health Maintenance Organizations, an independent association of health maintenance organizations whose purpose it is to represent the health maintenance organization industry on public policy, legislative and regulatory issues.

15. The following Arizona Association of Health Maintenance Organization members were in attendance regarding the potential purchase of the subject business:

a. PacifiCare of Arizona, Inc.

b. CIGNA Healthcare of Arizona, Inc.

c. Aetna U.S. Healthcare, Inc.

d. Humana Health Plan, Inc.

e. Blue Cross/Blue Shield of Arizona

f. Arizona Physicians, Inc./United Healthcare

g. Intergroup of Arizona, Inc.

h. Bankers Life Insurance Company

16. Each of the attending insurers declined to takeover the business of Premier, for reasons which included that none of the insurers had an adequate provider network in the rural areas served by Premier.

17. Subsequent to the meeting with the Arizona Association of Health Maintenance Organizations on November 17, 1999, the Receiver provided each of the attendees due diligence packages.

18. On December 22, 1999, the Receiver met with representatives of Healthcare Group of Arizona, a division of the Arizona Health Care Cost Containment System (AHCCCS)[6], to discuss a potential cession, transfer or transition of the Premier business to Healthcare Group. Healthcare Group was formed to facilitate affordable health insurance to Arizona employers experiencing difficulty in obtaining coverage, subject to certain eligibility requirements. Mercy Healthcare Group, Arizona Physicians, Inc. and University Physicians are contracted with AHCCCS pursuant to A.R.S. §§ 36-2901 et. seq.

19. On December 30, 1999, Director Cohen mailed a second letter to the approximate 85 Arizona "Accountable Health Plans"[7] offering to provide a due diligence package to insurers interested in transitioning some or all of Premier's business (see **Exhibit 13**).

20. Subsequently, the following insurers requested and received due diligence packages (see **Exhibit 14**):

a. Prudential HealthCare Plan of California, Inc.,

b. Golden Rule Insurance Company

c. John Deere Insurance Company

d. Unicare Life and Health Insurance Company

e. Aetna U.S. Healthcare, Inc.

f. Health Plan of Nevada, Inc.

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[6] AHCCCS was formed October 1, 1982 as the nation's first prepaid capitated health care system for low-income medically eligible individuals. Subsequently, in 1985, AHCCCS created Healthcare Group to offer commercial coverage to groups with less than fifty employees.

[7] An "accountable health plan" is defined in A.R.S. §20-2301 as "an entity that offers, issues or otherwise provides a health benefits plan and is approved by the director as an accountable health plan pursuant to A.R.S. §20-2303".

g. Progressive Financial New England

h. PacifiCare of Arizona, Inc.

i. Continental Assurance Company

j United Healthcare of Arizona, Inc.

21. From December 22, 1999 through March 24, 2000, the Receiver's representatives met and otherwise engaged in extensive discussions concerning the transfer of Premier's enrollees with representatives of Pacificare of Arizona, Inc., CIGNA Healthcare of Arizona, Inc. ("CIGNA"), Blue Cross/Blue Shield of Arizona, Intergroup of Arizona, Mercy Healthcare Group ("Mercycare"), Arizona Physicians,Inc./United Healthcare of Arizona, Inc., Humana Health Plan, Inc. and Aetna U.S. Healthcare Inc. Despite the Receiver's efforts, the insurance community demonstrated virtually no interest whatsoever in transitioning the Premier business because much of Premier's business was in rural Arizona communities where Premier was the only operating health plan. In addition, other insurers advised they would charge significantly higher premiums than Premier[8], and were concerned about the reaction this would receive from Premier's enrollees.

22. While efforts to transfer the Premier enrollment were ongoing, the Receiver actively assisted in the transition of enrollees not only through the statutorily mandated notice required by A.R.S. § 20-1069.01, but by advising employer groups of the impending termination of their coverage by Premier and informing them of other transition options including those under the availability of guaranteed issue of coverage pursuant to certain federal and state laws which require certain insurers which are "Accountable Health Plans" (see **Exhibit 15**) to provide coverage to small employer groups with at least two but not more than fifty employees without the imposition of new waiting periods for preexisting conditions. One consistent problem with the transition of enrollees was that the premiums charged by other carriers are substantially higher than those charged by Premier.

[8] Premier charged significantly lower premiums than other managed care plans and this may have been a factor that contributed to its insolvency.

23. In addition to the Accountable Health Plan laws, commercial (all non-Medicare) enrollees were advised of the provisions of A.R.S. § 20-1069.01 which provides for a mandatory open enrollment period upon the insolvency of the HCSO for enrollees who are members of a group with more than one insurance carrier. Further, the Receiver, brokers for the employer groups and the employer groups themselves acted to move Premier enrollees to other carriers.

24. As set forth above, HCFA terminated its Medicare contract with Premier effective December 1, 1999 and on that date 20,778 Medicare enrollees were removed from Premier enrollment and became at that time either traditional fee for service Medicare enrollees or, if a Medicare+Choice plan was available in the Medicare enrollee's geographic location, had a choice to enroll in such a plan.

25. Through the foregoing activities, Premier's enrollment was reduced to 5,887 by February 2000. On February 2, 2000, Mercy Healthcare Group provided a letter of intent to the Receiver offering "coverage to existing employer groups with fifty or fewer employees". Accordingly, the Receiver caused 3,289 of the remaining enrollees to be transferred to Mercy Healthcare Group[9]. Attached hereto as **Exhibit 16** is correspondence and an affidavit from Gen Re indicating its concurrence with the Mercy Healthcare Group transaction. Subsequently, on March 24, 2000, CIGNA provided a Letter of Intent to the Receiver, offering "coverage to the remaining employer groups…." As set forth in Petition No. 23, Petition for Order Approving Transition of Remaining Premier Enrollees,[10] the Receiver has transferred all remaining employer groups to CIGNA HealthCare of Arizona (CIGNA), effective May 1, 2000. Enclosed herewith as **Exhibit 17** is the Letter of Intent executed with CIGNA. Fortunately, the Receiver was able to transition the remaining groups which were unable to secure alternative coverage, to Mercy Healthcare Group and CIGNA, although no other proposals were received. As of May 1, 2000, Premier no longer had any enrollees.

IV. Premium Collection

[9] On February 25, 2000, the Court heard and approved Petition No. 14, Petition for Order Approving Transition of Enrollees, to Mercy Healthcare Group. United Healthcare Group, Inc. provided coverage to the remaining 150 Premier employees, effective April 1, 2000.

[10] On May 15, 2000 the Receiver filed Petition No. 23. A hearing to consider Petition No. 23 occurred on May 31, 2000 at which Petition No. 23 was approved.

26. The Receiver continues to face operational challenges resulting from discrepancies in Premier's records. At the time it was placed in receivership, Premier had multiple computer systems that contained inconsistent and inaccurate data, particularly as to enrollment. Reconciling and finalizing accurate eligibility roles for each month end (which, in turn, affects nearly every other aspect of the Company and the Receivership) continues to be one of the biggest challenges faced by the Receiver operationally. This issue has required the expenditure of substantial receivership resources. After a great deal of reconciliation work, much of which had to be processed manually, the Receiver determined that numerous employer groups covered by Premier had failed to pay premium as required by their contracts yet had not been terminated by Premier. The Receiver issued 802 letters to employers whose premium payments were in arrears notifying them that if premium was not brought current, Premier would, in accordance with law and the Group Service Agreement provisions, terminate coverage and seek to collect premium owed to Premier. The Receiver concluded, based in part upon his fiduciary obligation to the enrollees, the need for certainty and finality in the eligibility rolls of Premier, and the failure of pre-receivership Premier management to take timely and appropriate action against the failure of groups to pay premium, including the possible legal impact of such inaction, that each group should be reinstated to the date that each such group actually terminated coverage with Premier, such date not to exceed the termination date of the continuation of coverage provisions under the Plan for Risk of Insolvency, pursuant to A.R.S. § 20-1069.01, or the date the group became covered by another insurer. Any premium due Premier will be pursued, through litigation if necessary, once this eligibility process is concluded.

27. This process required the Receiver to determine, sometimes by direct contact with individual groups, the date that each group terminated coverage with Premier. Only when this date was known could the true eligibility date of each group be determined and the appropriate premium amount owed, if any, be calculated. This process has required substantial time and resources by the Receiver but has resulted in a near final determination of Premier's historic eligibility roles.

28. As of June 1, 2000, the Receiver has collected $9,668,755 in premium attributable to the post-receivership period and has paid claims of $12,304,150 in post-receivership claims. These amounts are broken down more fully in **Exhibit 1** attached hereto.

V. Provider Issues

29. As set forth above, the Receiver has spent a substantial amount of time communicating with both contract and non-contract providers in an effort to maintain the Premier delivery system so that Premier could comply with the statutory mandate to continue benefits for the statutorily imposed time periods. The Order required contract providers to continue to honor their obligations under their Premier contracts as long as Premier was obligated to continue to provide continuation of benefits. As a result of Premier's Receivership, many contract providers forwarded termination notices which were rejected by the Receiver. Although many contract providers expressed resistance to this Order, most contract providers continued to provide care to Premier enrollees. Moreover, most non-contract providers agreed to continue to see Premier enrollees based upon the Receiver's and Insurance Director's encouragement that they so do.

30. The Receiver and the ADOI continue to receive complaints from enrollees, including Premier's former Medicare enrollees, that contract and non-contract providers are attempting to collect from the enrollees in violation of Arizona law and the Order. A.R.S. § 20-1072 specifically prohibits any contract provider from collecting or attempting to collect against enrollees of an HCSO any amount owed by the HCSO. In response to the complaints that such collection efforts are occurring, as well as to other violations of the law and the Order, the Receiver continues to correspond with providers, in the form of letters, samples of which are set forth in **Exhibits 9, 10** and **11**, informing offending providers that such conduct is unlawful and that the Receiver will move to enforce the prohibition if the conduct does not immediately cease. Although contract providers attempting collection against Premier enrollees have ceased the collection activity once apprised of the law, the Receiver is investigating other complaints and will bring appropriate action in this Court if warranted by the results of the additional investigation.

VI. Premier Employees

31. There were approximately 216 employees as of November 16, 1999, the date of the Receivership Order. On that date, the Receiver offered employment to approximately 150 of the Premier employees as well as certain employees of MatureWell, Premier's parent. In order to encourage employees to continue their employment with Premier so long as the Receivership requires, the Receiver initiated an Employee Retention Plan, which was approved on February 7, 2000 by this Court through the Receiver's Petition For Approval Of Employee Retention Plan (Ex Parte Petition No. 8). The Plan provided certain incentives to all eligible employees who continued their full-time employment with Premier until termination of that employment by the Receiver. The terms of the Employee Retention Plan, including explanations of the conditions for eligibility and entitlement to payments, have been provided to all employees. Premier employs 28 employees at the present time and still requires the services of these employees in connection with the continued processing and payment of claims, both pre-and post-receivership.

C. Status of Pre-Receivership Claims Process

32. The pre-receivership claims process is the subject of ongoing discussions between the Receiver and an advisory committee of providers/claimants. A draft petition seeking approval of the pre-receivership claims process has been prepared as have the claim forms the Receiver proposes to use to implement the pre-receivership claims process. These documents have been distributed to the members of an advisory committee and other providers. Upon conclusion of the discussions with the advisory group, the petition to establish the pre-receivership claims process will be submitted to the Court for approval.

33. The draft petition referenced in paragraph 32 will also seek a liquidation order as the financial condition of Premier is such that rehabilitation is futile. On November 15, 1999, one day before the Order was entered, pre-receivership Premier management filed with ADOI a financial statement for the quarter ending September 30, 1999. That financial statement purports that Premier had $1,921,487 in capital and surplus as of September 30, 1999. One day after this quarterly financial statement was filed, Premier consented to the entry of the Order, including an admission that Premier was insolvent as of the date of the admission. Attached hereto **as Exhibit**

18 is a restatement of the September 30, 1999 financial statement for Premier prepared by the Receiver. As set forth in that restated financial statement, the Receiver believes that Premier had available and realizable assets of approximately $13,365,673 and liabilities of approximately $30,306,279 reflecting an insolvency of $16,940,606. The ADOI had serious concerns about the accuracy of Premier's financial statement, and had Premier not consented to the appointment of the Director as Receiver the day after the statement was filed, the ADOI would have challenged the representations contained in the statement through court proceedings. With the access to Premier's financial records and the time and technical expertise with which to analyze and reconcile those records, the Receiver was able to build upon the information obtained by the ADOI and to determine a more accurate picture of Premier's financial condition, including its failure to (i) post realistic claim liabilities, and (ii) reconcile bank statements. Moreover, the incomplete and inaccurate data contained in Premier's database on the date of receivership concerning eligibility and premiums due from employer groups substantially complicated the Receiver's efforts to ascertain Premier's true financial condition, and has been the single biggest challenge faced by the Receiver to date. As stated previously, eligibility drives virtually every other aspect of Premier's financial reporting, including claims payments, which cannot be adjudicated and paid until eligibility is reconciled. This process could not even be begun until the Receiver assumed control of Premier.

34. Attached hereto as **Exhibit 19** is a preliminary statement of the pre-receivership assets of Premier, **as of November 16, 1999**, both available and contingent. This asset amount cannot be compared to the figures set forth **Exhibit 18** and referenced in paragraph 33 because the corresponding liability side of the November 16, 1999 balance sheet will have also changed significantly from the September 30, 1999 figures. For example, for each dollar of premium which has been added to the assets of Premier from September 30, 1999 to November 16, 1999, more than one dollar in liabilities would also have to be added because of Premier's negative loss ratio. As set forth in **Exhibit 19**, the Receiver values those assets (both available and contingent) at $30,205,878 at this time and as the facts are now known. It is very likely that the amounts set

forth on both **Exhibits 18** and **19** will change as the contingencies related to some of the amounts are resolved and as the true financial condition of Premier becomes more clear.

WHEREFORE, the Receiver respectfully requests that the Court enter an Order accepting and approving this report and the exhibits attached hereto as the Receiver's first interim report regarding Premier Healthcare, Inc., d.b.a. Premier Healthcare of Arizona.

RESPECTFULLY SUBMITTED this _____ day of June, 2000.

JOSEPH M. HENNELLY, JR., P.C.

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